Department of Health

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Health Information Exchange (HIE) Advisory Commission
October 23, 2014
Meeting Minutes

Attendance:
Commission Members: David Gorelick,MD (Chair), Paula Hemond, Nicole Lagace, Lisa Shea, MD
Absent: Ted Almon
State Staff: Samara Viner-Brown, Amy Zimmerman
Guests: Alok Gupta (Rhode Island Quality Institute), Elaine Fontaine (Rhode Island Quality Institute), Alicia Maltz (Rhode Island Quality Institute)

1. **Meeting Called to Order:** at 3:30PM by Chair, Dr David Gorelick.
   a) Introductions
   b) Minutes (August 7, 2014) approved

2. **Public Comment:** None

3. **Recommendation Letter Related to Access to CurrentCare**
   - The group reviewed the draft recommendation letter to Dr. Fine regarding access to CurrentCare and "team-based healthcare". This recommendation was approved during the August meeting. The following corrections were mentioned: Paula Hemond's credentials should be: MS, RHIA; and Nicole Lagace's agency's name should be: HousingWorks RI at RWU.
   - The letter will be corrected and then sent to Dr. Fine for his review and response.

4. **Recommendations Related to Behavioral and Substance Abuse Data in CurrentCare**
   - The draft recommendation letter to Dr. Fine regarding the integration of substance abuse and alcohol treatment data from 42 CFR (Code of Federal Regulations) Part 2 facilities with CurrentCare was reviewed and approved by the Commission.
   - The same corrections as noted in number 3 above will be made, then it will be sent to Dr. Fine for his review and response.

5. **Analytics and CurrentCare (see attachment)**
   - Dr. Gorelick questioned whether physicians would be able to pull reports to determine who is due for screenings to help manage their care. He asked whether physicians could send a list of patients and find out who is active in CurrentCare to help identify those that need to still be signed up (the answere was yes) , as well as helping identify care needs (e.g., who had various screenings, such as, mammograms).
   - Elaine Fontaine (RIQI) presented information on how CurrentCare analytics can be used for population health management.

- CurrentCare has data that will allow providers to view patient data (CurrentCare Viewer) and to be notified of patient hospital encounters (via alerts). CurrentCare provides a longitudinal record for each patient. In addition to the viewer and alerts, a provider directory, patient portal and analytic capabilities are being implemented.
- Alerts are transactional and RIQI is exploring how they can be made "smarter" by assessing patient data and grouping them by types of severity, problems, etc. (e.g., chronic vs acute; asthma vs cut finger). This intelligent alerting process can then lead to decreases in avoidable care.
    - Babies discharged from the neonatal intensive care unit (NICU) are put on a watch list, and since implementation, readmissions have decreased by 50%.
- Dr Shea asked how CurrentCare deals with the fact that formularies change a lot. It was noted that at this time, CurrentCare does not collect formularies. CurrentCare is not currently not receiving Continuity of Care Documents (CCDs) from hospitals; CCDs include discharge diagnoses, etc. CurrentCare receives the ADT, which is a notification that the patient was in the hospital, but does not include details at discharge.
- Ms. Lagace asked whether the reason for going to the Emergency Room (ER) was captured in CurrentCare. The ADT message sent from the ER usually has a chief complaint in it and so that would be avaialbe to the provider getting the alert. There is some subscription-based alerting occuring whihc is based on "types" of patients (e.g., Congestive Heart Failure) who are then watched for ER visits after they are discharged from the hospital.
- CurrentCare (RIQI) staff are working to look at patterns of readmissions and other healthcare utilization. They are also meeting with practices to identify high risk patients and ensure they are getting the services they need. Dashboards are beginning to be created for practices.
- RIQI is exploring the ability to add functionality to allow physicians to have access to data on their patients as well as the practice as a whole. Ideally there would be a broad number of quality measures at the patient level.
- Ms. Lagace asked whether the system can indicate if patients are seeing specialists. Ms Fontaine responded that it depends if the specialists are participating in CurrentCare; they may not have electronic health records (EHRs). This raised the issue of whether alerts can be designed to indicate when patients are due for screenings (e.g., colonoscopy, mammography, etc.). This has complications in terms of setting up time frames for each screening, etc. A default could be to have the alert be triggered by the longest screening period.
- Dr. Gorelick suggested reports could use colors to indicate when patients are overdue for tests.
- Ms. Zimmerman raised the issue of patient mobility and how practices deal with enrolled and unenrolled patients.
- Ms. Lagace mentioned the importance of getting specialists into CurrentCare.
- Dr. Gorelick noted it would be useful if CurrentCare could provide data to the Health Department to show behaviors such as prescribing rates and patterns (e.g., antibiotics for specific conditions), ordering tests that don't meet standards, etc.
- Dr Shea mentioned that physicians can feel caught between prescribing for chronic pain and Drug Enforcement Agency reviews; and asked how practices can be supported.
- Ms Zimmerman stated that providers prescribing and other patterns can be used for public health purposes but if it was used for regulatory purposes, some providers may not want to participate in currentcare.

- It was noted that insurance companies do conduct quality reviews on providers and can identify excessive use (not using currentcare).
- Primary care practices can help coordinate their patients' care and share information with other healthcare providers.
- CurrentCare just started recieving data from Minute Clinics anywhere in the country.
- In terms of prescriptions, pharmacies submit prescriptions for controlled substances to the Prescription Monitoring Program (PMP). Currently, each state has its own PMP, and they are not connected. CurrentCare does receive prescriptions (inclduing and beyond controlled substances) from many but not all large pharmacy chains and for those that share data with curretncare it includes dispensed prescription data (both e-prescribed and handwritten) from anywehre in teh country. However, if the data are not in Sure Scripts, it may not be in CurrentCare. SureScripts does receive PMP data. **It was suggested that the topic of PMP and CurrentCare be considered for a future recommendation.**
- RIQI is reviewing operational metrics, such as use of alerts, records transmitted and matched, patient enrollment, etc. They have been examining readmission rates among those in practices with alerts (lower rates) vs. those with no alerts. Hospitalizations and emergency department visits have also been compared among those with and without alerts. It was mentioned that the differences were not as distinct when the data were controlled for those in practices classified as patient-centered medical homes (PCMHs). This may be due to nurse care managers in PCMHs who follow up on alerts as part of care management and practice transformation. CurrentCare can be viewed as an enabler to improve care.
- Ms. Fontaine noted that CurrentCare data can be used for public health surveillance. She shared the example where chlamydia screening rates were compared among CurrentCare enrollees, those with commercial and Medicaid coverage, and those enrolled in RI Chronic Sustainability Initiative (CSI) practices. Lower rates were seen among those in CurrentCare, although caveats to these findings were noted.
- CurrentCare data can also contribute to research studies and were identified in a Brown University Clinical Transformation Research grant application for patient level analyses and the provision of aggregated data.
- Dr. Shea, Dr. Gorelick, and Ms. Lagace commented that having a dashboard and providing data back to providers would be very helpful. The dashboard could be used to identify high risk patients and who is seeing specialists. Patients can list specialists via the patient portal. CurrentCare may help facilitate care coordination. For example, it will allow for monitoring whether recommended medications are prescribed for specific conditions; indicators can be designed to flag issues. The dashboard can be interfaced with physician EHR systems.
- **Recommendation: emphasize CurrentCare dashboard and continue the direction**

6. Schedule and Topics for Future Meetings

- Future Commission meetings will be held on the first Thursday of every other month at 3:30pm. The next meeting will be held on December 4th. The meeting schedule will be sent with the minutes.
- Staff will confirm how many members are needed to achieve a quorum.
- It was noted that current members need to be reappointed once their two-year term ends on June 30, 2015 or new members would need to be appointed.

- Topics for future meetings include enrollment, consumer interaction with data, patient portal and the Prescription Monitoring Program. It was agreed that CurrentCare's Patient Portal and enrollment will be discussed at the next meeting.
- Dr. Gorelick mentioned that he is on the RIQI Board meeting email distribution which provides an invitation to the open meetings, minutes, agenda, as well as the CEO's letter. The members agreed that it would be appropriate for all to be on the distribution as well. Amy Zimmerman will send a request to have all of the commission members added to the email distribution.
- The Health Department has hired staff to oversee health information technology initiatives and public health informatics. Melissa Lauer will be starting on November 3 and will be staffing these HIE Commission meetings.

7. Meeting Adjourned at 4:59pm